CORRINA R. LYNCH | CPC PREPARATION

ICD-10-CM GUIDELINES

2026 CARTOON LEARNING CARDS

I.C.2-22 | Chapter-Specific Rules

FIND THE GUIDELINE FIRST

The large reference number is the primary label. IV.J means Section IV (four), letter J. Character names are memory aids, not guideline numbers.

EVERY TEACHING CARD

Read: guideline reference and topic > setting > rule in plain language > fictional patient example > code answer or coding action and why. Use the Index first and verify the Tabular List.

MARISOL VEGA: WHERE TO LOOK

The Marisol example has its own IV.J card in Part 4. Also see I.B.5-6 and I.C.18.b for integral versus unrelated symptoms.

WHAT THIS EDITION CONTAINS

This part has 176 teaching cards. The series has 362 teaching cards across Sections I-IV. Long rules have been split or summarized for instruction; the separate Official Text + Examples companion preserves all official wording on printed pages 7-115.

SOURCE & CODE DETAILS

Based on the original FY 2026 release updated October 1, 2025. All fully specified example codes were checked against the official FY 2026 code-description file. A code ending in a dash is a lookup family, not a reportable final code. When details are missing, the card gives the coding action rather than inventing them.

Official CMS guidelines (click to open)

GUIDELINE FINDER

Select an entry or search the PDF for a guideline number.

I.C.2 | Neoplasms: general guidelines **8**

I.C.2 | Primary malignant neoplasms overlapping site boundaries **8**

I.C.2 | Malignant neoplasm of ectopic tissue **9**

I.C.2.a; I.C.2.l.1 | Treatment of primary malignancy **9**

I.C.2.b; I.C.2.l.2 | Treatment of secondary malignancy **10**

I.C.2.c.1 | Anemia associated with malignancy **10**

I.C.2.c.2 | Anemia due to chemotherapy **11**

I.C.2.c.3 | Dehydration due to malignancy **11**

I.C.2.c.4 | Complication of surgery for neoplasm **12**

I.C.2.d; I.C.2.m | Current malignancy versus personal history **12**

I.C.2.e.1 | Surgery followed by adjunct therapy **13**

I.C.2.e.2 | Encounter chiefly for antineoplastic therapy **13**

I.C.2.e.2 | Brachytherapy **14**

I.C.2.e.3 | Therapy admission with complications **14**

I.C.2.f | Determine extent of malignancy **15**

I.C.2.g | Symptoms associated with malignancy **15**

I.C.2.h; I.C.6.b.5 | Neoplasm-related pain management **16**

I.C.2.i | Malignancy at noncontiguous sites **16**

I.C.2.j | Disseminated malignant neoplasm, unspecified **17**

I.C.2.k | Malignant neoplasm without specification of site **17**

I.C.2.l.3 | Malignancy in pregnancy **18**

I.C.2.l.4 | Complication associated with neoplasm **18**

I.C.2.l.5 | Complication of neoplasm treatment **19**

I.C.2.n | Remission versus personal history **19**

I.C.2.o | Aftercare following surgery for neoplasm **20**

I.C.2.p | Follow-up after completed malignancy treatment **20**

I.C.2.q | Prophylactic organ removal **21**

I.C.2.r | Malignancy associated with transplanted organ **21**

I.C.2.s | Breast implant-associated anaplastic large cell lymphoma **22**

I.C.2.t | Secondary malignant neoplasm of lymphoid tissue **22**

GUIDELINE FINDER

Select an entry or search the PDF for a guideline number.

I.C.3 | Blood and immune disorders **23**

I.C.4.a.1 | Diabetes type and manifestations **23**

I.C.4.a.1(a) | Presymptomatic type 1 diabetes **24**

I.C.4.a.1(b) | Type 2 diabetes in remission **24**

I.C.4.a.2 | Diabetes type not documented **25**

I.C.4.a.3 | Diabetes and long-term medication use **25**

I.C.4.a.5(a) | Insulin pump failure: underdose **26**

I.C.4.a.5(b) | Insulin pump failure: overdose **26**

I.C.4.a.6 | Secondary diabetes mellitus **27**

I.C.4.b | Obesity **27**

I.C.5.a | Pain disorders related to psychological factors **28**

I.C.5.b.1 | Psychoactive substance use: hierarchy **28**

I.C.5.b.2 | Substance-related disorders: clinical significance **29**

I.C.5.c | Factitious disorder **29**

I.C.6.a | Dominant/nondominant side **30**

I.C.6.b.1 | Pain: underlying diagnosis **30**

I.C.6.b.1(a) | Pain control as reason for encounter **31**

I.C.6.b.1(b) | Site-specific pain and G89 **31**

I.C.6.b.3 | Postoperative pain **32**

I.C.6.b.4; I.C.6.b.6 | Chronic pain versus chronic pain syndrome **32**

I.C.7.a | Assigning glaucoma codes **33**

I.C.7.a | Glaucoma stage: unspecified versus indeterminate **33**

I.C.7.b | Blindness **34**

I.C.8 | Ear and mastoid disorders **34**

I.C.9.a.1 | Hypertensive heart disease **35**

I.C.9.a.2 | Hypertensive chronic kidney disease **35**

I.C.9.a.3 | Hypertensive heart and chronic kidney disease **36**

I.C.9.a.4 | Hypertensive cerebrovascular disease **36**

I.C.9.a.5 | Hypertensive retinopathy **37**

I.C.9.a.6 | Secondary hypertension **37**

GUIDELINE FINDER

Select an entry or search the PDF for a guideline number.

I.C.9.a.7 | Transient hypertension **38**

I.C.9.a.8-9 | Controlled and uncontrolled hypertension **38**

I.C.9.a.10 | Hypertensive crisis **39**

I.C.9.a.11 | Pulmonary hypertension **39**

I.C.9.a.12 | Resistant hypertension **40**

I.C.9.b | Coronary atherosclerosis and angina **40**

I.C.9.c | Intraoperative and postprocedural cerebrovascular accident **41**

I.C.9.d | Sequelae of cerebrovascular disease **41**

I.C.9.e | Acute myocardial infarction **42**

I.C.9.e | Subsequent acute myocardial infarction **42**

I.C.10.a | COPD and asthma: exacerbation versus infection **43**

I.C.10.b | Acute respiratory failure **43**

I.C.10.c | Influenza due to identified viruses **44**

I.C.10.d | Ventilator-associated pneumonia **44**

I.C.10.e | Vaping-related disorders **45**

I.C.11 | Digestive system disorders **45**

I.C.12.a | Pressure ulcer site and stage **46**

I.C.12.a | Unstageable versus unspecified stage **46**

I.C.12.a | Pressure-induced deep tissue damage **47**

I.C.12.a | Healing pressure ulcers **47**

I.C.12.a | Pressure ulcer progression during admission **48**

I.C.12.b | Non-pressure chronic ulcers **48**

I.C.13.a | Site and laterality **49**

I.C.13.b | Acute traumatic versus chronic musculoskeletal conditions **49**

I.C.13.c | Pathologic fractures **50**

I.C.13.d | Osteoporosis with current pathological fracture **50**

I.C.13.d | Osteoporosis without current pathological fracture **51**

I.C.13.e | Multisystem inflammatory syndrome **51**

I.C.14.a.1 | Stages of chronic kidney disease **52**

I.C.14.a.2 | CKD and kidney transplant status **52**

GUIDELINE FINDER

Select an entry or search the PDF for a guideline number.

I.C.14.a.3 | CKD with other conditions **53**

I.C.15.a | Obstetric codes and maternal record **53**

I.C.15.a | Trimester and weeks of gestation **54**

I.C.15.a | Fetus identification **54**

I.C.15.b | Selection of obstetric principal diagnosis **55**

I.C.15.c | Pre-existing versus pregnancy-induced conditions **55**

I.C.15.d | Pre-existing hypertension in pregnancy **56**

I.C.15.e | Fetal conditions affecting maternal management **56**

I.C.15.f | HIV in pregnancy **57**

I.C.15.g | Diabetes mellitus in pregnancy **57**

I.C.15.h | Long-term antidiabetic medication in pregnancy **58**

I.C.15.i | Gestational diabetes **58**

I.C.15.j; I.C.15.k | Obstetric sepsis and puerperal sepsis **59**

I.C.15.l | Alcohol, tobacco and drug use in pregnancy **59**

I.C.15.m | Poisoning and adverse effects in pregnancy **60**

I.C.15.n | Normal delivery, O80 **60**

I.C.15.o | Peripartum and postpartum periods **61**

I.C.15.p | Sequelae of obstetric complications **61**

I.C.15.q | Termination of pregnancy and spontaneous abortions **62**

I.C.15.r | Abuse in a pregnant patient **62**

I.C.15.s | COVID-19 in pregnancy **63**

I.C.16.a | Perinatal versus maternal record **63**

I.C.16.a | Birth record and transfer **64**

I.C.16.a; I.C.16.c | Clinically significant newborn conditions **64**

I.C.16.b | Observation of suspected newborn conditions not found **65**

I.C.16.d; I.C.16.e | Prematurity, low birth weight and immaturity **65**

I.C.16.f | Bacterial sepsis of newborn **66**

I.C.16.g | Stillbirth **66**

I.C.16.h | COVID-19 infection in newborn **67**

I.C.17 | Congenital malformations and chromosomal abnormalities **67**

GUIDELINE FINDER

Select an entry or search the PDF for a guideline number.

I.C.18.a | Use of symptom codes **68**

I.C.18.b | Symptoms with definitive diagnoses **68**

I.C.18.c | Combination codes that include symptoms **69**

I.C.18.d | Repeated falls **69**

I.C.18.e | Coma and Glasgow coma scale **70**

I.C.18.f | Functional quadriplegia **70**

I.C.18.g | SIRS due to a noninfectious process **71**

I.C.18.h | Death NOS **71**

I.C.18.i | NIH Stroke Scale **72**

I.C.19.a | Initial encounter **72**

I.C.19.a | Subsequent encounter **73**

I.C.19.a | Sequela **73**

I.C.19.b | Coding injuries **74**

I.C.19.c | Traumatic fractures **74**

I.C.19.c | Open fractures and healing **75**

I.C.19.d | Burns and corrosions **75**

I.C.19.d | Burn depth at same site **76**

I.C.19.e.1-4 | Drug and chemical table conventions **76**

I.C.19.e.5(a) | Adverse effects of correct use **77**

I.C.19.e.5(b) | Poisoning **77**

I.C.19.e.5(c) | Underdosing **78**

I.C.19.e.5(d) | Toxic effects **78**

I.C.19.f | Adult and child abuse, neglect and maltreatment **79**

I.C.19.g | Complications of care **79**

I.C.19.g | Transplant complications **80**

I.C.20.a | External cause coding: general rules **80**

I.C.20.b | Place of occurrence **81**

I.C.20.c | Activity **81**

I.C.20.d | Place, activity and status with other causes **82**

I.C.20.e | Reporting-format limits **82**

GUIDELINE FINDER

Select an entry or search the PDF for a guideline number.

I.C.20.f | Multiple external causes **83**

I.C.20.g | Abuse external causes **83**

I.C.20.h | Unknown versus undetermined intent **84**

I.C.20.i | Sequelae of external causes **84**

I.C.20.j | Terrorism **85**

I.C.20.k | External cause status **85**

I.C.21.a | Z codes in any setting **86**

I.C.21.b | Reason for encounter or extra information **86**

I.C.21.c.1 | Contact/exposure **87**

I.C.21.c.2 | Inoculations and vaccinations **87**

I.C.21.c.3 | Status **88**

I.C.21.c.4 | History **88**

I.C.21.c.5 | Screening **89**

I.C.21.c.6 | Observation **89**

I.C.21.c.7 | Aftercare **90**

I.C.21.c.8 | Follow-up **90**

I.C.21.c.9 | Donors **91**

I.C.21.c.10 | Counseling **91**

I.C.21.c.11 | Encounters for obstetrical and reproductive services **92**

I.C.21.c.12 | Routine and administrative examinations **92**

I.C.21.c.13 | Miscellaneous Z codes **93**

I.C.21.c.14 | Nonspecific Z codes **93**

I.C.21.c.15 | Z codes usable only as principal/first-listed **94**

I.C.21.c.16 | Newborns and infants **94**

I.C.21.c.17 | Social determinants of health **95**

I.C.22 | Codes for Special Purposes **95**

I.C.2

Neoplasms: general guidelines

ALL SETTINGS



GUIDELINE IN PLAIN LANGUAGE

Determine behavior, site and any secondary sites; look up a documented histologic term first, otherwise start with the Neoplasm Table. Verify the Tabular List.

FICTIONAL PATIENT EXAMPLE

Nora's provider documents a primary malignant neoplasm of sigmoid colon.

CODING ANSWER / ACTION + WHY

C18.7. Follow Neoplasm, colon, sigmoid, malignant primary; confirm the full code.

I.C.2

Primary malignant neoplasms overlapping site boundaries

ALL SETTINGS



GUIDELINE IN PLAIN LANGUAGE

Use an overlapping-lesion code for a primary tumor crossing contiguous sites unless specifically indexed elsewhere. Separate noncontiguous tumors need site codes.

FICTIONAL PATIENT EXAMPLE

Nora has two noncontiguous primary breast tumors in different quadrants.

CODING ANSWER / ACTION + WHY

Code each documented site after verifying laterality and patient details. Do not assume an overlapping lesion.

I.C.2

Malignant neoplasm of ectopic tissue

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

Code ectopic malignant tissue to its site of origin rather than the organ where it lies.

FICTIONAL PATIENT EXAMPLE

Nora has ectopic pancreatic cancer involving the stomach.



CODING ANSWER / ACTION + WHY

C25.9. The malignant tissue is pancreatic in origin; verify the Index and Tabular List.

I.C.2.a; I.C.2.l.1

Treatment of primary malignancy

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

When care treats the primary cancer, generally list it first; therapy-only and other special rules can override.

FICTIONAL PATIENT EXAMPLE

Nora's encounter is for surgical treatment of active sigmoid colon cancer, not chemotherapy-only administration.



CODING ANSWER / ACTION + WHY

C18.7 first. The visit treats the primary site.

I.C.2.b; I.C.2.l.2

Treatment of secondary malignancy

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

When treatment targets only a metastatic site, that site leads; add the primary cancer when present.

FICTIONAL PATIENT EXAMPLE

Active sigmoid colon cancer has spread to the liver. Today's procedure treats only the liver metastasis.



CODING ANSWER / ACTION + WHY

C78.7 first, then C18.7. Treatment is directed at the secondary site.

I.C.2.c.1

Anemia associated with malignancy

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

For treatment only of anemia caused by malignancy, code the malignancy before the anemia.

FICTIONAL PATIENT EXAMPLE

Nora is admitted only for transfusion for anemia caused by active sigmoid colon cancer.



CODING ANSWER / ACTION + WHY

C18.7 then D63.0. The malignancy-first exception applies.

I.C.2.c.2

Anemia due to chemotherapy

ALL SETTINGS



GUIDELINE IN PLAIN LANGUAGE

If only anemia due to a correctly administered chemotherapy drug is treated, anemia leads, followed by malignancy and drug adverse-effect code.

FICTIONAL PATIENT EXAMPLE

Nora has chemotherapy-induced anemia and active sigmoid colon cancer; the visit treats only anemia.

CODING ANSWER / ACTION + WHY

D64.81, C18.7, T45.1X5A during active treatment. This is a treatment adverse effect, not cancer-caused anemia.

I.C.2.c.3

Dehydration due to malignancy

ALL SETTINGS



GUIDELINE IN PLAIN LANGUAGE

When treatment is only for dehydration due to cancer, dehydration leads, followed by malignancy.

FICTIONAL PATIENT EXAMPLE

Nora receives IV fluids solely for dehydration due to active sigmoid colon cancer.

CODING ANSWER / ACTION + WHY

E86.0 then C18.7. The treated complication leads under this rule.

I.C.2.c.4

Complication of surgery for neoplasm

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

When treating a surgical complication, code the complication first if it is the reason for care.

FICTIONAL PATIENT EXAMPLE

Nora returns for treatment of a provider-documented infection due to a prior cancer operation.



CODING ANSWER / ACTION + WHY

Verify the specific complication code first. Obtain site, depth and encounter details before assigning it.

I.C.2.d; I.C.2.m

Current malignancy versus personal history

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

Use history when the primary site is eradicated, no disease remains there and no further treatment is directed to it.

FICTIONAL PATIENT EXAMPLE

Nora's breast cancer was fully excised; treatment is complete and no malignancy remains.



CODING ANSWER / ACTION + WHY

Z85.3 when relevant. Do not code active breast cancer.

I.C.2.e.1

Surgery followed by adjunct therapy

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

If the same episode includes surgical removal of the tumor followed by adjunct chemotherapy, the neoplasm leads.

FICTIONAL PATIENT EXAMPLE

Nora undergoes removal of sigmoid colon cancer and adjunct chemotherapy during the same episode.



CODING ANSWER / ACTION + WHY

C18.7 first. This is not a visit solely to administer chemotherapy.

I.C.2.e.2

Encounter chiefly for antineoplastic therapy

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

For chemotherapy, immunotherapy or external beam radiation administration alone, the applicable encounter code leads; add the cancer.

FICTIONAL PATIENT EXAMPLE

Nora attends only for chemotherapy for active sigmoid colon cancer.



CODING ANSWER / ACTION + WHY

Z51.11 then C18.7. Immunotherapy-only uses Z51.12; external radiation-only uses Z51.0.

I.C.2.e.2

Brachytherapy

ALL SETTINGS



GUIDELINE IN PLAIN LANGUAGE

For insertion or implantation of radioactive elements, the malignancy leads rather than the external-radiation encounter code.

FICTIONAL PATIENT EXAMPLE

Nora receives implanted radioactive elements for her documented malignancy.

CODING ANSWER / ACTION + WHY

Code the verified malignancy first; do not assign Z51.0 merely for implantation.

I.C.2.e.3

Therapy admission with complications

INPATIENT ONLY



GUIDELINE IN PLAIN LANGUAGE

If admission is for antineoplastic therapy and a complication develops during that stay, the therapy encounter remains principal.

FICTIONAL PATIENT EXAMPLE

Nora is admitted for chemotherapy for sigmoid colon cancer and develops dehydration afterward.

CODING ANSWER / ACTION + WHY

Z51.11 remains principal; add C18.7 and E86.0 as reportable diagnoses.

I.C.2.f

Determine extent of malignancy

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

When care determines the extent of malignancy, or performs a procedure directed to it, the primary or metastatic malignancy leads, even if therapy is also given.

FICTIONAL PATIENT EXAMPLE

Nora's encounter evaluates the extent of active sigmoid colon cancer.



CODING ANSWER / ACTION + WHY

C18.7 first when it is the relevant primary site. Do not treat the visit as therapy-only.

I.C.2.g

Symptoms associated with malignancy

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

Do not replace a known cancer with a characteristic symptom as first-listed or principal when care is for the neoplasm.

FICTIONAL PATIENT EXAMPLE

Nora's visit treats known sigmoid colon cancer; abdominal discomfort is attributed to it.



CODING ANSWER / ACTION + WHY

C18.7 leads. A routine related symptom does not replace the cancer.

I.C.2.h; I.C.6.b.5

Neoplasm-related pain management

ALL SETTINGS



GUIDELINE IN PLAIN LANGUAGE

When the encounter is specifically for cancer pain control, the neoplasm-related pain code can lead, followed by the cancer.

FICTIONAL PATIENT EXAMPLE

Nora attends solely for control of pain caused by active sigmoid colon cancer.

CODING ANSWER / ACTION + WHY

G89.3 then C18.7. The purpose is pain management, not tumor-directed treatment.

I.C.2.i

Malignancy at noncontiguous sites

ALL SETTINGS



GUIDELINE IN PLAIN LANGUAGE

If unclear whether tumors are separate primaries or metastatic disease, query the provider.

FICTIONAL PATIENT EXAMPLE

Nora has two documented tumors, but the record does not establish their relationship.

CODING ANSWER / ACTION + WHY

Query before final code selection; do not label the second lesion metastatic on assumption.

I.C.2.j

Disseminated malignant neoplasm, unspecified

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

Use C80.0 only for advanced disseminated malignancy with no specified primary or secondary sites.

FICTIONAL PATIENT EXAMPLE

Nora's record says disseminated malignancy and identifies no primary or metastatic site.



CODING ANSWER / ACTION + WHY

C80.0. Do not substitute it when specific sites are known.

I.C.2.k

Malignant neoplasm without specification of site

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

Use the unspecified-primary cancer code only when the primary site cannot be determined.

FICTIONAL PATIENT EXAMPLE

Nora has documented cancer, with no determined primary site or further site detail.



CODING ANSWER / ACTION + WHY

C80.1. Verify that the primary site truly cannot be determined.

I.C.2.I.3

Malignancy in pregnancy

OBSTETRIC RECORD

GUIDELINE IN PLAIN LANGUAGE

An obstetric code for malignancy complicating pregnancy leads, followed by the cancer code.

FICTIONAL PATIENT EXAMPLE

Nora is 20 weeks pregnant with sigmoid colon cancer affecting pregnancy care.



CODING ANSWER / ACTION + WHY

Verify the second-trimester O9A.1- code first, then C18.7; add gestational weeks as applicable.

I.C.2.I.4

Complication associated with neoplasm

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

For care only for a cancer complication, that complication usually leads; malignancy-associated anemia is an exception.

FICTIONAL PATIENT EXAMPLE

Nora receives only treatment for dehydration due to colon cancer.



CODING ANSWER / ACTION + WHY

E86.0 then C18.7. Contrast this with cancer-caused anemia.

I.C.2.l.5

Complication of neoplasm treatment

ALL SETTINGS



GUIDELINE IN PLAIN LANGUAGE

For treatment of a complication caused by cancer therapy, code the complication first when it drives the encounter.

FICTIONAL PATIENT EXAMPLE

Nora's visit is only for chemotherapy-induced anemia from correct drug use.

CODING ANSWER / ACTION + WHY

D64.81 first; add the malignancy and T45.1X5A during active adverse-effect treatment.

I.C.2.n

Remission versus personal history

ALL SETTINGS



GUIDELINE IN PLAIN LANGUAGE

For leukemia, multiple myeloma and malignant plasma-cell neoplasms, distinguish remission from eradicated personal history. Query unclear status.

FICTIONAL PATIENT EXAMPLE

Nora's leukemia is described only as resolved, without clear remission or history status.

CODING ANSWER / ACTION + WHY

Query the provider. Do not select a remission or personal-history code from that phrase alone.

I.C.2.o

Aftercare following surgery for neoplasm

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

Use aftercare when the encounter is surgical recovery care, rather than active cancer treatment or surveillance after completed care.

FICTIONAL PATIENT EXAMPLE

Nora returns for uncomplicated recovery after cancer surgery.



CODING ANSWER / ACTION + WHY

Verify Z48.3 and other supported codes. Do not confuse recovery care with completed-treatment follow-up.

I.C.2.p

Follow-up after completed malignancy treatment

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

After treatment is complete and no cancer remains, use follow-up plus the relevant history code.

FICTIONAL PATIENT EXAMPLE

Nora has a normal cancer surveillance exam after all breast cancer treatment is complete.



CODING ANSWER / ACTION + WHY

Z08 then Z85.3. There is no active malignancy or ongoing aftercare.

I.C.2.q

Prophylactic organ removal

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

Use the appropriate prophylactic-removal encounter code when removal prevents cancer, rather than treating an existing malignancy.

FICTIONAL PATIENT EXAMPLE

Nora has prophylactic breast removal because of documented risk; no breast cancer exists.



CODING ANSWER / ACTION + WHY

Verify Z40.01 and add documented risk or genetic susceptibility as applicable.

I.C.2.r

Malignancy associated with transplanted organ

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

For malignancy associated with a transplant, code the transplant complication first, then C80.2 and the specific malignancy.

FICTIONAL PATIENT EXAMPLE

Nora has a provider-confirmed malignancy associated with a transplanted organ.



CODING ANSWER / ACTION + WHY

Verify the specific T86.- complication, then C80.2 and the malignancy. The transplanted organ must be identified.

I.C.2.s

Breast implant-associated anaplastic large cell lymphoma

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

Use the lymphoma classification rather than coding the condition as a mechanical breast implant complication.

FICTIONAL PATIENT EXAMPLE

Nora has confirmed breast implant-associated anaplastic large cell lymphoma.



CODING ANSWER / ACTION + WHY

C84.7A. Verify the diagnosis-specific code; do not substitute a routine implant complication.

I.C.2.t

Secondary malignant neoplasm of lymphoid tissue

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

Lymphoid neoplasms involving other sites are classified with lymphoid neoplasms rather than automatically as solid-organ metastases.

FICTIONAL PATIENT EXAMPLE

Nora has a documented lymphoid neoplasm involving a non-lymphoid organ.



CODING ANSWER / ACTION + WHY

Follow the histology-specific Index entry and Chapter 2 guidance; do not default to C78/C79 solely for organ involvement.

I.C.3

Blood and immune disorders

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

This chapter has no separate chapter-specific guideline expansion here. Apply conventions, general rules and applicable Tabular notes.

FICTIONAL PATIENT EXAMPLE

Nora has provider-documented iron deficiency anemia, unspecified cause.



CODING ANSWER / ACTION + WHY

D50.9 after verification. This is a general-rule illustration, not a new Chapter 3 rule.

I.C.4.a.1

Diabetes type and manifestations

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

Diabetes codes combine type, affected system and complications. Use as many category codes as needed for distinct manifestations.

FICTIONAL PATIENT EXAMPLE

Maya has type 2 diabetes with hyperglycemia and diabetic CKD stage 3b.



CODING ANSWER / ACTION + WHY

E11.65, E11.22 and N18.32 as applicable. Do not add E11.9 for the same diabetes.

I.C.4.a.1(a)

Presymptomatic type 1 diabetes

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

Use the E10.A- pathway when the provider documents presymptomatic type 1 diabetes; do not infer the stage from tests.

FICTIONAL PATIENT EXAMPLE

Maya's provider confirms presymptomatic type 1 diabetes, with stage documented.



CODING ANSWER / ACTION + WHY

Verify the complete E10.A- stage code. Additional detail is needed before choosing the leaf code.

I.C.4.a.1(b)

Type 2 diabetes in remission

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

E11.A requires provider documentation of remission; resolved is not synonymous with remission.

FICTIONAL PATIENT EXAMPLE

Maya's provider documents type 2 diabetes without complications in remission.



CODING ANSWER / ACTION + WHY

E11.A. Query if the documentation instead leaves remission unclear.

I.C.4.a.2

Diabetes type not documented

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

The default type is type 2 when the type is not documented. Insulin use alone does not establish type 1.

FICTIONAL PATIENT EXAMPLE

Maya has diabetes without a stated type and no complication; no medication coding requested.



CODING ANSWER / ACTION + WHY

E11.9. Do not infer type 1 from age or insulin use.

I.C.4.a.3

Diabetes and long-term medication use

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

Add applicable long-term insulin, oral or injectable non-insulin drug status for type 2 diabetes. Temporary insulin does not justify long-term status.

FICTIONAL PATIENT EXAMPLE

Maya has uncomplicated type 2 diabetes treated long-term with insulin and metformin.



CODING ANSWER / ACTION + WHY

E11.9, Z79.4 and Z79.84. For long-term non-insulin injections, verify Z79.85 as applicable.

I.C.4.a.5(a)

Insulin pump failure: underdose

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

A pump malfunction causing underdose is sequenced before insulin underdosing and diabetes manifestations.

FICTIONAL PATIENT EXAMPLE

Maya's insulin pump malfunctions, causing underdosing and hyperglycemia.



CODING ANSWER / ACTION + WHY

Verify the specific T85.6- pump malfunction first, then T38.3X6A during active treatment and the applicable diabetes manifestation.

I.C.4.a.5(b)

Insulin pump failure: overdose

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

Pump malfunction causing overdose also leads, followed by accidental poisoning by insulin.

FICTIONAL PATIENT EXAMPLE

Maya's pump delivers excess insulin; the provider diagnoses poisoning due to the malfunction.



CODING ANSWER / ACTION + WHY

Verify the pump malfunction, then T38.3X1A during active treatment; add supported manifestations.

I.C.4.a.6

Secondary diabetes mellitus

ALL SETTINGS



GUIDELINE IN PLAIN LANGUAGE

For secondary diabetes, identify the underlying cause and follow code-first or use-additional-code directions. Drug adverse effects and poisoning differ.

FICTIONAL PATIENT EXAMPLE

Maya has diabetes caused by an underlying diagnosed pancreatic disorder.

CODING ANSWER / ACTION + WHY

Verify E08.- and the code-first instruction; sequence the underlying condition first. Do not default to E11.-.

I.C.4.b

Obesity

ALL SETTINGS



GUIDELINE IN PLAIN LANGUAGE

Base obesity type/class on provider documentation; follow specific classification directions and use additional BMI when appropriate.

FICTIONAL PATIENT EXAMPLE

Maya's provider diagnoses obesity without class or type; a dietitian documents adult BMI 33.0.

CODING ANSWER / ACTION + WHY

E66.9 and Z68.33 when reportable. Do not infer obesity class from BMI alone.

I.C.5.a

Pain disorders related to psychological factors

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

For pain exclusively related to psychological factors, use the applicable F45 code rather than G89. Psychological factors associated with other pain are different.

FICTIONAL PATIENT EXAMPLE

Morgan's provider states the pain is exclusively psychological.



CODING ANSWER / ACTION + WHY

F45.41. If psychological factors are associated with other pain, verify F45.42 and relevant pain coding instead.

I.C.5.b.1

Psychoactive substance use: hierarchy

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

When use, abuse and dependence are documented for the same substance, apply the hierarchy: dependence overrides abuse and use.

FICTIONAL PATIENT EXAMPLE

Morgan's provider documents alcohol abuse and alcohol dependence without complication.



CODING ANSWER / ACTION + WHY

F10.20. Do not separately report abuse of the same substance.

I.C.5.b.2

Substance-related disorders: clinical significance

ALL SETTINGS



GUIDELINE IN PLAIN LANGUAGE

Substance-related diagnoses require provider documentation and applicable reporting criteria. Do not infer a disorder from a positive test.

FICTIONAL PATIENT EXAMPLE

Morgan's urine test is positive, but the provider has not diagnosed a substance use disorder.

CODING ANSWER / ACTION + WHY

Do not assign a use/abuse/dependence disorder solely from the test. Clarify when indicated.

I.C.5.c

Factitious disorder

ALL SETTINGS



GUIDELINE IN PLAIN LANGUAGE

Distinguish factitious disorder imposed on self from that imposed on another. A victim's record follows the abuse guidance.

FICTIONAL PATIENT EXAMPLE

Morgan is diagnosed with factitious disorder imposed on self.

CODING ANSWER / ACTION + WHY

Verify the appropriate F68.1- code based on the documented presentation; do not code the fabricated illness as confirmed.

I.C.6.a

Dominant/nondominant side

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

When the affected side is known but dominance is not, default right to dominant and left to nondominant; ambidextrous defaults dominant when no contrary classification direction exists.

FICTIONAL PATIENT EXAMPLE

Morgan has hemiplegia after an old cerebral infarction affecting the left side; dominance is not documented.



CODING ANSWER / ACTION + WHY

I69.354. Verify the Index and Tabular List; left defaults to nondominant in this case.

I.C.6.b.1

Pain: underlying diagnosis

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

Do not routinely add G89 when the underlying diagnosis is known and care is for that underlying condition rather than pain management.

FICTIONAL PATIENT EXAMPLE

Morgan receives treatment of right knee osteoarthritis; pain is routine to it.



CODING ANSWER / ACTION + WHY

M17.11. Do not add a generic pain-management code for this visit.

I.C.6.b.1(a)

Pain control as reason for encounter

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

When pain management is the purpose, the appropriate G89 code can lead; add the underlying cause or site as appropriate.

FICTIONAL PATIENT EXAMPLE

Morgan attends solely for management of documented chronic low back pain without a known cause.



CODING ANSWER / ACTION + WHY

G89.29 then M54.50. Chronic pain is documented; chronic pain syndrome is not.

I.C.6.b.1(b)

Site-specific pain and G89

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

If care is not pain management and no definitive cause is known, site pain generally leads, with G89 adding supported detail.

FICTIONAL PATIENT EXAMPLE

Morgan's office evaluation is for chronic low back pain with no established cause.



CODING ANSWER / ACTION + WHY

M54.50 then G89.29. The visit evaluates the symptom rather than providing pain management alone.

I.C.6.b.3

Postoperative pain

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

Routine expected immediate postoperative pain is not separately coded. Nonroutine postoperative pain follows documentation and complication instructions.

FICTIONAL PATIENT EXAMPLE

Morgan's provider diagnoses acute postprocedural pain requiring a separate treatment visit, with no specific complication.



CODING ANSWER / ACTION + WHY

G89.18. Do not apply this code to routine immediate recovery pain.

I.C.6.b.4; I.C.6.b.6

Chronic pain versus chronic pain syndrome

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

Chronic pain is based on provider documentation, not a fixed duration. Chronic pain syndrome must be specifically diagnosed.

FICTIONAL PATIENT EXAMPLE

Morgan has documented chronic pain syndrome.



CODING ANSWER / ACTION + WHY

G89.4. Do not infer the syndrome merely from long-standing pain.

I.C.7.a

Assigning glaucoma codes

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

Report the documented glaucoma type, eye and stage. Bilateral disease with different types or stages can require separate eye-specific codes.

FICTIONAL PATIENT EXAMPLE

Avery has bilateral glaucoma, but only the right-eye stage is documented.



CODING ANSWER / ACTION + WHY

Verify the eye-specific coding and clarify the missing stage; do not copy the right stage to the left.

I.C.7.a

Glaucoma stage: unspecified versus indeterminate

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

Indeterminate means the stage cannot clinically be determined; unspecified means it was not documented. If the stage progresses during an admission, code the highest stage documented.

FICTIONAL PATIENT EXAMPLE

Avery's clinician explicitly cannot determine glaucoma stage.



CODING ANSWER / ACTION + WHY

Choose the indeterminate-stage option after verifying type and laterality. Do not confuse it with omitted documentation.

I.C.7.b

Blindness

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

Use documented visual impairment categories. If the provider documents blindness without the needed category, follow the guideline's available code pathway rather than inferring severity from measurements.

FICTIONAL PATIENT EXAMPLE

Avery has provider-documented blindness in both eyes with no category detail.



CODING ANSWER / ACTION + WHY

Verify H54.3 for unqualified visual loss, both eyes, under this guidance. Do not invent a specific visual category.

I.C.8

Ear and mastoid disorders

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

No separate chapter-specific guideline expansion is provided here. Apply the Index, Tabular List and general rules.

FICTIONAL PATIENT EXAMPLE

Avery has bilateral ear pain without an established disease.



CODING ANSWER / ACTION + WHY

H92.03. This illustrates general coding, not a new Chapter 8 convention.

I.C.9.a.1

Hypertensive heart disease

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

The classification presumes hypertension with specified heart conditions is related unless documented otherwise. Add the heart failure type when required.

FICTIONAL PATIENT EXAMPLE

Sam has hypertension and chronic systolic heart failure, not documented as unrelated.



CODING ANSWER / ACTION + WHY

I11.0 then I50.22. Verify the hypertensive heart disease notes.

I.C.9.a.2

Hypertensive chronic kidney disease

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

Presume the hypertension-CKD relationship unless the provider says unrelated. Add CKD stage.

FICTIONAL PATIENT EXAMPLE

Sam has hypertension and CKD stage 3b, with no unrelated statement.



CODING ANSWER / ACTION + WHY

I12.9 then N18.32. The stage is an additional code.

I.C.9.a.3

Hypertensive heart and chronic kidney disease

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

Use I13 when hypertension coexists with qualifying heart disease and CKD. Add heart failure and CKD detail as instructed.

FICTIONAL PATIENT EXAMPLE

Sam has hypertension, chronic systolic heart failure and CKD stage 3b.



CODING ANSWER / ACTION + WHY

I13.0, I50.22 and N18.32. Follow Tabular sequencing instructions.

I.C.9.a.4

Hypertensive cerebrovascular disease

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

For hypertensive cerebrovascular disease, sequence the appropriate cerebrovascular code before hypertension.

FICTIONAL PATIENT EXAMPLE

Sam's provider documents a cerebrovascular condition attributed to hypertension.



CODING ANSWER / ACTION + WHY

Verify the specific I60-I69 diagnosis first, then the hypertension code. The exact cerebrovascular diagnosis is needed.

I.C.9.a.5

Hypertensive retinopathy

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

Use the retinal code and systemic hypertension code; sequencing depends on the reason for care.

FICTIONAL PATIENT EXAMPLE

Sam has bilateral hypertensive retinopathy and essential hypertension, both addressed.



CODING ANSWER / ACTION + WHY

H35.033 and I10. Select first-listed based on the encounter purpose.

I.C.9.a.6

Secondary hypertension

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

Secondary hypertension requires the underlying etiology and the appropriate secondary hypertension code; sequence by reason for care.

FICTIONAL PATIENT EXAMPLE

Sam's hypertension is explicitly due to a specified renal disorder.



CODING ANSWER / ACTION + WHY

Verify the renal disease and I15.- subtype. Do not call it essential hypertension.

I.C.9.a.7

Transient hypertension

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

An elevated blood pressure reading without diagnosed hypertension is not essential hypertension.

FICTIONAL PATIENT EXAMPLE

Sam has one high blood pressure reading; the provider does not diagnose hypertension.



CODING ANSWER / ACTION + WHY

R03.0. Do not infer I10 from the reading.

I.C.9.a.8-9

Controlled and uncontrolled hypertension

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

Controlled or uncontrolled wording does not by itself establish a different hypertension type or crisis.

FICTIONAL PATIENT EXAMPLE

Sam has documented uncontrolled essential hypertension without crisis, heart disease or CKD.



CODING ANSWER / ACTION + WHY

I10. Uncontrolled alone does not mean hypertensive emergency.

I.C.9.a.10

Hypertensive crisis

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

Code documented urgency, emergency or unspecified crisis from I16; add identified hypertensive disease as instructed and sequence by encounter circumstances.

FICTIONAL PATIENT EXAMPLE

Sam has provider-documented hypertensive urgency and essential hypertension.



CODING ANSWER / ACTION + WHY

I16.0 and I10 as directed. Verify sequencing from the encounter and notes.

I.C.9.a.11

Pulmonary hypertension

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

Code the specific documented type and associated causes or conditions according to Tabular instructions.

FICTIONAL PATIENT EXAMPLE

Sam has pulmonary hypertension but its type is not documented.



CODING ANSWER / ACTION + WHY

I27.20 after verification. Do not infer a group from a test result alone.

I.C.9.a.12

Resistant hypertension

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

Add I1A.0 when the provider documents resistant hypertension, after the specific hypertension type when known.

FICTIONAL PATIENT EXAMPLE

Sam has essential hypertension explicitly diagnosed as resistant.



CODING ANSWER / ACTION + WHY

I10 then I1A.0. Do not infer resistance just from several medications.

I.C.9.b

Coronary atherosclerosis and angina

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

Use the combination code when coronary atherosclerosis and angina are linked by classification; do not add a separate angina code for the same condition.

FICTIONAL PATIENT EXAMPLE

Sam has native coronary artery atherosclerosis with unstable angina.



CODING ANSWER / ACTION + WHY

I25.110. The combination code identifies both conditions.

I.C.9.c

Intraoperative and postprocedural cerebrovascular accident

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

A stroke after a procedure is not automatically a complication. The provider must establish the relationship and relevant timing.

FICTIONAL PATIENT EXAMPLE

Sam has a stroke after surgery, but no causal relationship is documented.



CODING ANSWER / ACTION + WHY

Clarify when indicated before assigning a procedural complication code; verify the diagnosed stroke separately.

I.C.9.d

Sequelae of cerebrovascular disease

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

Use I69 for residual deficits from prior cerebrovascular disease; the deficit can persist indefinitely. History is for prior disease without residuals.

FICTIONAL PATIENT EXAMPLE

Sam has aphasia due to a prior cerebral infarction.



CODING ANSWER / ACTION + WHY

I69.320. Do not replace the residual code with history alone.

I.C.9.e

Acute myocardial infarction

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

AMI codes use the acute timeframe and documented type/site. An old healed infarction no longer receiving care uses the old-MI pathway.

FICTIONAL PATIENT EXAMPLE

Sam has an old healed MI with no current care for it.



CODING ANSWER / ACTION + WHY

I25.2 when reportable. Do not treat an old infarction as acute.

I.C.9.e

Subsequent acute myocardial infarction

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

A new type 1 or unspecified AMI within four weeks of an earlier AMI can require I22 together with I21; verify types and sites.

FICTIONAL PATIENT EXAMPLE

Sam has a new qualifying infarction two weeks after an earlier AMI.



CODING ANSWER / ACTION + WHY

Verify both the I21.- and I22.- instructions using type and site; sequence according to the encounter. Do not use I22 for every recurrent MI.

I.C.10.a

COPD and asthma: exacerbation versus infection

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

An acute exacerbation differs from an infection. Code both when both are documented and follow additional-infection instructions.

FICTIONAL PATIENT EXAMPLE

Lee has COPD with acute exacerbation and pneumonia, unspecified organism, both diagnosed.



CODING ANSWER / ACTION + WHY

J44.0, J44.1 and J18.9 as applicable; use the Tabular notes to sequence the infection relationship.

I.C.10.b

Acute respiratory failure

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

Respiratory failure may be principal when it chiefly occasions admission, subject to chapter priorities. With another acute condition, circumstances govern; query unclear cases.

FICTIONAL PATIENT EXAMPLE

Lee is admitted chiefly for documented acute respiratory failure with hypoxia; no overriding sequencing rule applies.



CODING ANSWER / ACTION + WHY

J96.01 principal. Do not diagnose failure solely from oxygen values.

I.C.10.c

Influenza due to identified viruses

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

Certain identified influenza-virus categories require confirmed cases, even in inpatient care. Do not infer the identified virus from suspected wording.

FICTIONAL PATIENT EXAMPLE

Lee's discharge says possible avian influenza without confirmation.



CODING ANSWER / ACTION + WHY

Do not assign the identified-virus category solely on this wording; use the supported influenza or symptom pathway after review.

I.C.10.d

Ventilator-associated pneumonia

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

The provider must specifically document ventilator association. Add organism detail as instructed.

FICTIONAL PATIENT EXAMPLE

Lee develops pneumonia while ventilated, but the provider does not identify VAP.



CODING ANSWER / ACTION + WHY

Do not infer J95.851 from ventilation plus pneumonia alone; clarify the relationship when indicated.

I.C.10.e

Vaping-related disorders

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

For documented vaping-related disorder, use U07.0 and report other manifestations as instructed; do not separately code integral respiratory findings.

FICTIONAL PATIENT EXAMPLE

Lee's provider diagnoses vaping-related lung injury.



CODING ANSWER / ACTION + WHY

U07.0. Verify the exclusions and any separately reportable associated conditions.

I.C.11

Digestive system disorders

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

No separate chapter-specific guideline expansion appears here. Apply the classification and general rules.

FICTIONAL PATIENT EXAMPLE

Lee has documented chronic diarrhea with an Index route to noninfective enteritis/colitis.



CODING ANSWER / ACTION + WHY

Verify K52.9 through the chronic diarrhea Index entry; do not search the Tabular List by exact provider phrase alone.

I.C.12.a

Pressure ulcer site and stage

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

Pressure ulcer codes combine site and stage. Use as many codes as needed for different sites and stages.

FICTIONAL PATIENT EXAMPLE

Jo has a provider-diagnosed stage 3 sacral pressure ulcer.



CODING ANSWER / ACTION + WHY

L89.153. Verify sacral location and stage.

I.C.12.a

Unstageable versus unspecified stage

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

Unstageable is a clinically documented inability to determine the stage; unspecified means stage is not documented. Do not interchange them.

FICTIONAL PATIENT EXAMPLE

Jo's sacral ulcer cannot be staged because it is covered by eschar.



CODING ANSWER / ACTION + WHY

L89.150 when documented as unstageable. Do not call it unspecified stage.

I.C.12.a

Pressure-induced deep tissue damage

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

Use the deep-tissue-damage option when that pressure-related condition is documented; do not infer an ordinary stage.

FICTIONAL PATIENT EXAMPLE

Jo has documented pressure-induced deep tissue damage of the sacral region.



CODING ANSWER / ACTION + WHY

L89.156. Verify the site-specific deep tissue code.

I.C.12.a

Healing pressure ulcers

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

A healing ulcer keeps its documented stage; a completely healed ulcer is not coded as a current ulcer.

FICTIONAL PATIENT EXAMPLE

Jo's stage 3 sacral ulcer is healing but not healed.



CODING ANSWER / ACTION + WHY

L89.153. Do not invent a lower stage because it is healing.

I.C.12.a

Pressure ulcer progression during admission

INPATIENT ONLY

GUIDELINE IN PLAIN LANGUAGE

When an ulcer progresses to a higher stage during admission, report the admission stage and the highest stage reached under the guideline.

FICTIONAL PATIENT EXAMPLE

Jo is admitted with a stage 2 sacral ulcer that progresses to stage 3.



CODING ANSWER / ACTION + WHY

L89.152 and L89.153 under the progression rule; assess POA separately for each as applicable.

I.C.12.b

Non-pressure chronic ulcers

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

Use documented site, laterality and severity for non-pressure ulcers. Apply associated-condition instructions and the healing/progression rules.

FICTIONAL PATIENT EXAMPLE

Jo's provider diagnoses a non-pressure chronic ulcer, but the record lacks site and severity.



CODING ANSWER / ACTION + WHY

Obtain the missing details before choosing a specific L97/L98 code; do not substitute a pressure-ulcer code.

I.C.13.a

Site and laterality

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

Use the affected bone, joint or muscle site and side. Use multiple-site coding only when appropriate under the classification.

FICTIONAL PATIENT EXAMPLE

Jo has primary osteoarthritis of the right knee.



CODING ANSWER / ACTION + WHY

M17.11. Verify joint and laterality.

I.C.13.b

Acute traumatic versus chronic musculoskeletal conditions

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

Current traumatic injuries generally follow Chapter 19; chronic or recurrent conditions generally follow Chapter 13 when classified there.

FICTIONAL PATIENT EXAMPLE

Jo has chronic recurrent musculoskeletal disease without a current injury.



CODING ANSWER / ACTION + WHY

Follow the specific disease Index entry; do not assign an acute injury code merely because pain worsened.

I.C.13.c

Pathologic fractures

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

Use the pathologic-fracture pathway for a provider-diagnosed pathologic fracture and the appropriate treatment-phase character.

FICTIONAL PATIENT EXAMPLE

Jo's provider documents a pathologic fracture due to a neoplasm.



CODING ANSWER / ACTION + WHY

Verify the neoplasm-related fracture code and sequencing based on whether care treats the fracture or cancer; exact site/side are needed.

I.C.13.d

Osteoporosis with current pathological fracture

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

Use M80 for osteoporosis with a current pathological fracture. A minor event can cause such a fracture in osteoporosis; provider diagnosis guides coding.

FICTIONAL PATIENT EXAMPLE

Jo has a provider-diagnosed osteoporotic pathological femur fracture after a minor event.



CODING ANSWER / ACTION + WHY

Verify M80.- with site, side and encounter phase. Do not assume a traumatic fracture solely because a fall occurred.

I.C.13.d

Osteoporosis without current pathological fracture

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

Use M81 when there is no current pathological fracture; report relevant healed-fracture history as applicable.

FICTIONAL PATIENT EXAMPLE

Jo has age-related osteoporosis without a current fracture.



CODING ANSWER / ACTION + WHY

M81.0. Verify whether any relevant fracture history should be added.

I.C.13.e

Multisystem inflammatory syndrome

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

For MIS associated with current or prior COVID-19, apply the specific COVID/MIS sequencing pathways.

FICTIONAL PATIENT EXAMPLE

Jo has MIS due to a prior resolved COVID-19 infection.



CODING ANSWER / ACTION + WHY

M35.81 and U09.9; add separately reportable complications.

I.C.14.a.1

Stages of chronic kidney disease

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

Code the provider-documented CKD stage. If ESRD and a CKD stage coexist in documentation, follow the ESRD instruction.

FICTIONAL PATIENT EXAMPLE

Kai has documented CKD stage 3b.



CODING ANSWER / ACTION + WHY

N18.32. Do not infer the stage from a lab value alone.

I.C.14.a.2

CKD and kidney transplant status

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

CKD after kidney transplant is not automatically a transplant complication. Add transplant status when applicable; complications need documentation.

FICTIONAL PATIENT EXAMPLE

Kai has CKD stage 3b and a functioning transplanted kidney; no transplant complication.



CODING ANSWER / ACTION + WHY

N18.32 and Z94.0. Do not infer transplant failure.

I.C.14.a.3

CKD with other conditions

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

Sequence CKD with associated diabetes, hypertension and other conditions by their specific instructions.

FICTIONAL PATIENT EXAMPLE

Kai has diabetic CKD stage 3b, type 2.



CODING ANSWER / ACTION + WHY

E11.22 then N18.32. The diabetes code requires stage detail.

I.C.15.a

Obstetric codes and maternal record

OBSTETRIC RECORD

GUIDELINE IN PLAIN LANGUAGE

Chapter 15 codes generally take priority on the maternal record. Do not place maternal obstetric codes on the newborn's record.

FICTIONAL PATIENT EXAMPLE

Rae is pregnant and receives care for an infection affecting pregnancy.



CODING ANSWER / ACTION + WHY

Verify the applicable obstetric infection code first, then identify the infection as instructed. Use a separate newborn record at birth.

I.C.15.a

Trimester and weeks of gestation

OBSTETRIC RECORD



GUIDELINE IN PLAIN LANGUAGE

Select trimester from provider documentation and add gestational-week detail as applicable; use the documented gestational age rather than calculation from unrelated dates.

FICTIONAL PATIENT EXAMPLE

Rae has a pregnancy complication at 20 completed weeks.

CODING ANSWER / ACTION + WHY

Choose the appropriate second-trimester code and add Z3A.20 when applicable.

I.C.15.a

Fetus identification

OBSTETRIC RECORD



GUIDELINE IN PLAIN LANGUAGE

When required, select the seventh character identifying the affected fetus; do not assume fetus number when it matters.

FICTIONAL PATIENT EXAMPLE

Rae has a twin-pregnancy complication requiring fetus identification, but the affected fetus is unclear.

CODING ANSWER / ACTION + WHY

Clarify or apply the specific unspecified-fetus instruction as permitted. Do not guess the fetus number.

I.C.15.b

Selection of obstetric principal diagnosis

OBSTETRIC RECORD



GUIDELINE IN PLAIN LANGUAGE

For delivery or antepartum care, identify the condition chiefly responsible and apply Chapter 15 sequencing instructions. Add outcome of delivery on the maternal delivery record.

FICTIONAL PATIENT EXAMPLE

Rae delivers one liveborn infant in an otherwise uncomplicated full-term delivery.

CODING ANSWER / ACTION + WHY

O80 with Z37.0. Verify that no complication disqualifies O80.

I.C.15.c

Pre-existing versus pregnancy-induced conditions

OBSTETRIC RECORD



GUIDELINE IN PLAIN LANGUAGE

Distinguish a pre-existing condition from one caused by pregnancy. The code choice depends on provider documentation.

FICTIONAL PATIENT EXAMPLE

Rae had diabetes before pregnancy rather than developing gestational diabetes.

CODING ANSWER / ACTION + WHY

Use the applicable O24 pre-existing diabetes code and required diabetes detail, not the gestational diabetes category.

I.C.15.d

Pre-existing hypertension in pregnancy

OBSTETRIC RECORD

GUIDELINE IN PLAIN LANGUAGE

Use the appropriate obstetric hypertension code; add the underlying heart/CKD type and detail when the classification directs it.

FICTIONAL PATIENT EXAMPLE

Rae has pre-existing hypertension and CKD complicating pregnancy.



CODING ANSWER / ACTION + WHY

Verify the O10.- subtype first and add hypertensive disease and CKD codes as directed. Trimester and organ detail are needed.

I.C.15.e

Fetal conditions affecting maternal management

OBSTETRIC RECORD

GUIDELINE IN PLAIN LANGUAGE

A fetal condition is reported on the maternal record when it alters maternal management; its mere presence is not enough.

FICTIONAL PATIENT EXAMPLE

A suspected fetal abnormality prompts additional maternal evaluation and changes delivery planning.



CODING ANSWER / ACTION + WHY

Verify the applicable maternal-care O35/O36 code using the documented condition and affected fetus.

I.C.15.f

HIV in pregnancy

OBSTETRIC RECORD



GUIDELINE IN PLAIN LANGUAGE

Sequence the O98.7- code before HIV disease or asymptomatic HIV status, according to the documented state.

FICTIONAL PATIENT EXAMPLE

Rae has asymptomatic HIV status complicating pregnancy, without prior HIV-related illness.

CODING ANSWER / ACTION + WHY

Applicable O98.7- code then Z21. Do not automatically use B20.

I.C.15.g

Diabetes mellitus in pregnancy

OBSTETRIC RECORD



GUIDELINE IN PLAIN LANGUAGE

For pre-existing diabetes complicating pregnancy, use O24 first, followed by diabetes codes describing its manifestations.

FICTIONAL PATIENT EXAMPLE

Rae has pre-existing type 2 diabetes with hyperglycemia during pregnancy.

CODING ANSWER / ACTION + WHY

Verify the O24.- trimester code first, then E11.65; add gestational weeks as applicable.

I.C.15.h

Long-term antidiabetic medication in pregnancy

OBSTETRIC RECORD



GUIDELINE IN PLAIN LANGUAGE

Add applicable long-term insulin, oral or non-insulin injection status for pre-existing diabetes; do not apply that approach to gestational diabetes without checking its instructions.

FICTIONAL PATIENT EXAMPLE

Rae's pre-existing type 2 diabetes is treated long-term with insulin.

CODING ANSWER / ACTION + WHY

After the appropriate obstetric and diabetes codes, add Z79.4 when applicable.

I.C.15.i

Gestational diabetes

OBSTETRIC RECORD



GUIDELINE IN PLAIN LANGUAGE

Gestational diabetes uses O24.4; identify control method. Do not also add pre-existing diabetes or routine Z79 insulin status for the same gestational diabetes.

FICTIONAL PATIENT EXAMPLE

Rae has insulin-controlled gestational diabetes during pregnancy.

CODING ANSWER / ACTION + WHY

O24.414. Verify the pregnancy versus childbirth/puerperium branch.

I.C.15.j; I.C.15.k

Obstetric sepsis and puerperal sepsis

OBSTETRIC RECORD

GUIDELINE IN PLAIN LANGUAGE

Follow the specific obstetric sepsis instructions and identify the organism and severe sepsis details as directed. Do not use the ordinary adult sequence without reviewing Chapter 15.

FICTIONAL PATIENT EXAMPLE

Rae has documented puerperal sepsis.



CODING ANSWER / ACTION + WHY

Verify O85, organism and any severe sepsis/acute dysfunction codes as applicable. Clarify the organism and severity if needed.

I.C.15.l

Alcohol, tobacco and drug use in pregnancy

OBSTETRIC RECORD

GUIDELINE IN PLAIN LANGUAGE

Use the appropriate O99.- code for documented use complicating pregnancy, with substance-related detail as directed.

FICTIONAL PATIENT EXAMPLE

Rae's provider documents tobacco use complicating pregnancy.



CODING ANSWER / ACTION + WHY

Verify O99.33- and the applicable tobacco-use/dependence code. Trimester and substance detail are needed.

I.C.15.m

Poisoning and adverse effects in pregnancy

OBSTETRIC RECORD



GUIDELINE IN PLAIN LANGUAGE

For a pregnancy-related poisoning or similar event, apply O9A.2- sequencing and add the Chapter 19 cause and manifestation codes as directed.

FICTIONAL PATIENT EXAMPLE

Rae accidentally overdoses on diazepam, affecting pregnancy, and receives active treatment.

CODING ANSWER / ACTION + WHY

Applicable O9A.2- code first, then T42.4X1A and supported manifestations.

I.C.15.n

Normal delivery, O80

OBSTETRIC RECORD



GUIDELINE IN PLAIN LANGUAGE

O80 is for full-term uncomplicated delivery of a single healthy infant. Do not use it with another Chapter 15 complication code.

FICTIONAL PATIENT EXAMPLE

Rae has a full-term uncomplicated delivery of one healthy liveborn infant.

CODING ANSWER / ACTION + WHY

O80 and Z37.0. Do not use O80 when a pregnancy/delivery complication exists.

I.C.15.o

Peripartum and postpartum periods

OBSTETRIC RECORD



GUIDELINE IN PLAIN LANGUAGE

The postpartum period ordinarily extends six weeks after delivery. A later complication can still be pregnancy related when the provider documents the link.

FICTIONAL PATIENT EXAMPLE

Rae's provider links a condition eight weeks after delivery to pregnancy.

CODING ANSWER / ACTION + WHY

Follow the documented obstetric relationship and appropriate code; do not reject it solely because six weeks passed.

I.C.15.p

Sequelae of obstetric complications

ALL SETTINGS



GUIDELINE IN PLAIN LANGUAGE

For a residual from a previous obstetric complication after its acute phase, code the residual and add O94 as directed.

FICTIONAL PATIENT EXAMPLE

Rae is treated for a persistent residual explicitly due to a prior resolved obstetric complication.

CODING ANSWER / ACTION + WHY

Code the specific residual first and O94 second. Do not use an acute obstetric complication as still current.

I.C.15.q

Termination of pregnancy and spontaneous abortions

OBSTETRIC RECORD



GUIDELINE IN PLAIN LANGUAGE

Distinguish the event, retained products and complications using documentation. Follow the specific abortion and attempted-termination rules.

FICTIONAL PATIENT EXAMPLE

Rae has a documented spontaneous abortion, but completeness and complications are not clarified.

CODING ANSWER / ACTION + WHY

Obtain needed details and verify the O03.- pathway. Do not assume complete or uncomplicated from silence when the record conflicts.

I.C.15.r

Abuse in a pregnant patient

OBSTETRIC RECORD



GUIDELINE IN PLAIN LANGUAGE

For abuse complicating pregnancy, use the relevant O9A.3-O9A.5 code first, followed by injury, abuse and perpetrator detail as directed.

FICTIONAL PATIENT EXAMPLE

Rae is treated for physical abuse affecting pregnancy.

CODING ANSWER / ACTION + WHY

Verify the O9A.3- code first and the applicable abuse/injury codes. Use the documented trimester and confirmation status.

I.C.15.s

COVID-19 in pregnancy

OBSTETRIC RECORD

GUIDELINE IN PLAIN LANGUAGE

When COVID-19 affects pregnancy care, the obstetric code takes priority over U07.1; add manifestations as applicable.

FICTIONAL PATIENT EXAMPLE

Rae has COVID-19 pneumonia complicating pregnancy.



CODING ANSWER / ACTION + WHY

Applicable O98.5- code first, then U07.1 and J12.82, with gestational weeks as applicable.

I.C.16.a

Perinatal versus maternal record

NEWBORN/PERINATAL

GUIDELINE IN PLAIN LANGUAGE

Perinatal codes describe conditions originating in that period, not every illness in an infant. Keep the newborn and maternal records separate.

FICTIONAL PATIENT EXAMPLE

A newborn has a condition explicitly diagnosed as originating before birth.



CODING ANSWER / ACTION + WHY

Verify the applicable P-code; do not copy the mother's obstetric diagnosis onto the newborn record.

I.C.16.a

Birth record and transfer

NEWBORN/PERINATAL

GUIDELINE IN PLAIN LANGUAGE

On the birth record, Z38 identifies liveborn place/type of birth and is principal. Do not use it again on a transfer or later admission.

FICTIONAL PATIENT EXAMPLE

A single liveborn infant is born in hospital by vaginal delivery.



CODING ANSWER / ACTION + WHY

Z38.00 on the birth record. Do not reuse it for the receiving hospital's transfer admission.

I.C.16.a; I.C.16.c

Clinically significant newborn conditions

NEWBORN/PERINATAL

GUIDELINE IN PLAIN LANGUAGE

Report conditions requiring care, evaluation, monitoring or resources, and documented conditions with implications for future needs. This expanded criterion is not an adult rule.

FICTIONAL PATIENT EXAMPLE

A newborn's diagnosed condition requires extra monitoring and affects future care planning.



CODING ANSWER / ACTION + WHY

Report the verified condition in addition to the birth code as appropriate. Do not apply the future-needs exception to adult records.

I.C.16.b

Observation of suspected newborn conditions not found

NEWBORN/PERINATAL

GUIDELINE IN PLAIN LANGUAGE

Use Z05 when a healthy newborn is observed for a suspected condition that is ruled out. Symptoms require a different pathway.

FICTIONAL PATIENT EXAMPLE

A healthy newborn is observed for suspected infection; it is ruled out and no symptoms occur.



CODING ANSWER / ACTION + WHY

Z05.1 as additional on the birth record; on a later applicable admission it may be principal.

I.C.16.d; I.C.16.e

Prematurity, low birth weight and immaturity

NEWBORN/PERINATAL

GUIDELINE IN PLAIN LANGUAGE

Provider documentation establishes prematurity/growth conditions. When both birth weight and gestational age codes apply, sequence birth weight first.

FICTIONAL PATIENT EXAMPLE

A clinician diagnoses a premature low-birth-weight infant with both measurements documented.



CODING ANSWER / ACTION + WHY

Verify the applicable P07 weight code first and gestational-age code second; use birth measurements, not later weight.

I.C.16.f

Bacterial sepsis of newborn

NEWBORN/PERINATAL

GUIDELINE IN PLAIN LANGUAGE

Use the newborn bacterial-sepsis category. Add organism detail if not captured; apply newborn-specific severe sepsis rules when relevant.

FICTIONAL PATIENT EXAMPLE

A provider diagnoses bacterial sepsis of newborn with organism unspecified.



CODING ANSWER / ACTION + WHY

P36.9. Do not substitute the ordinary adult sepsis code.

I.C.16.g

Stillbirth

NEWBORN/PERINATAL

GUIDELINE IN PLAIN LANGUAGE

P95 is used on the stillborn infant record when the cause cannot be determined; do not use it on the mother's record.

FICTIONAL PATIENT EXAMPLE

The stillborn infant record has no determined cause.



CODING ANSWER / ACTION + WHY

P95. The maternal record follows obstetric outcome coding instead.

I.C.16.h

COVID-19 infection in newborn

NEWBORN/PERINATAL

GUIDELINE IN PLAIN LANGUAGE

For a newborn testing positive, apply the infection rule; use congenital-infection coding as directed when the provider documents acquisition in utero or during birth.

FICTIONAL PATIENT EXAMPLE

A newborn has confirmed COVID-19 acquired after birth.



CODING ANSWER / ACTION + WHY

U07.1. Do not assume congenital acquisition solely because the patient is a newborn.

I.C.17

Congenital malformations and chromosomal abnormalities

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

Congenital codes may apply throughout life while the condition persists. After correction, relevant history coding may apply. Do not infer congenital disease from age alone.

FICTIONAL PATIENT EXAMPLE

An adult still has an unrepaired ventricular septal defect.



CODING ANSWER / ACTION + WHY

Q21.0. The congenital condition does not cease to be coded because of adult age.

I.C.18.a

Use of symptom codes

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

Use symptoms when no related definitive diagnosis is established, subject to setting-specific uncertainty rules.

FICTIONAL PATIENT EXAMPLE

Avery's outpatient evaluation ends with right lower quadrant pain and no cause.



CODING ANSWER / ACTION + WHY

R10.31. Do not infer appendicitis.

I.C.18.b

Symptoms with definitive diagnoses

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

Do not separately report routine integral symptoms; unrelated or nonroutine symptoms may be reported when appropriate.

FICTIONAL PATIENT EXAMPLE

Marisol has acute cystitis without hematuria and separately evaluated unrelated dizziness.



CODING ANSWER / ACTION + WHY

N30.00 and R42. The dizziness is not routine to the diagnosed infection in this record.

I.C.18.c

Combination codes that include symptoms

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

Do not add a symptom separately when a combination code already captures it.

FICTIONAL PATIENT EXAMPLE

Avery has type 2 diabetes with hyperglycemia.



CODING ANSWER / ACTION + WHY

E11.65. Do not duplicate the same hyperglycemia with a separate symptom code.

I.C.18.d

Repeated falls

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

Repeated falls and a history of falling describe different concepts and may both apply when both are documented.

FICTIONAL PATIENT EXAMPLE

Avery is evaluated for recent repeated falls; no cause is established.



CODING ANSWER / ACTION + WHY

R29.6. Add Z91.81 when a relevant past history/risk is also documented and reportable.

I.C.18.e

Coma and Glasgow coma scale

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

Code the documented condition and apply coma-scale instructions. Do not infer a coma diagnosis or scale score from an isolated description.

FICTIONAL PATIENT EXAMPLE

Avery has a documented coma; a permitted clinician records a Glasgow coma scale score.



CODING ANSWER / ACTION + WHY

Verify the coma diagnosis and applicable R40.2- scale/timing codes. Do not code a scale without the required context.

I.C.18.f

Functional quadriplegia

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

Functional quadriplegia describes complete inability to move due to severe disability/frailty, not neurologic quadriplegia. Provider documentation is required.

FICTIONAL PATIENT EXAMPLE

Avery's provider diagnoses functional quadriplegia due to severe frailty.



CODING ANSWER / ACTION + WHY

R53.2 when reportable. Do not infer it from bed confinement alone.

I.C.18.g

SIRS due to a noninfectious process

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

For noninfectious SIRS, code the underlying condition first, then R65.1- and related acute organ dysfunction as applicable.

FICTIONAL PATIENT EXAMPLE

Avery has provider-diagnosed noninfectious SIRS due to a burn, without acute organ dysfunction.



CODING ANSWER / ACTION + WHY

Burn code first, then R65.10. Do not label it sepsis without infection.

I.C.18.h

Death NOS

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

R99 has a narrow use when a patient is already deceased on arrival and no cause is determined; do not append it routinely to a hospital death record.

FICTIONAL PATIENT EXAMPLE

Avery arrives deceased, and no cause of death is established.



CODING ANSWER / ACTION + WHY

R99 under this specific circumstance. Do not use it merely because death occurred during care.

I.C.18.i

NIH Stroke Scale

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

NIHSS codes are additional to a documented acute stroke and may come from permitted clinician documentation.

FICTIONAL PATIENT EXAMPLE

Avery has acute stroke; the stroke team records NIHSS 5.



CODING ANSWER / ACTION + WHY

Add R29.705 after the verified acute stroke diagnosis when reportable; the score does not establish the stroke.

I.C.19.a

Initial encounter

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

A indicates active treatment, even when delivered by a different provider or at a later visit.

FICTIONAL PATIENT EXAMPLE

Avery has active removal of a foreign body on the external left eye, part unspecified.



CODING ANSWER / ACTION + WHY

T15.92XA. X preserves the seventh position; A means active treatment.

I.C.19.a

Subsequent encounter

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

D generally represents routine recovery after active treatment, with fracture-specific healing characters where applicable.

FICTIONAL PATIENT EXAMPLE

Avery returns for routine healing care after removal of the same foreign body.



CODING ANSWER / ACTION + WHY

T15.92XD. It is recovery care, not a new active treatment episode.

I.C.19.a

Sequela

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

For a residual after injury's acute phase, generally code the residual first and the injury code with S second.

FICTIONAL PATIENT EXAMPLE

Avery has a scar contracture from a healed burn.



CODING ANSWER / ACTION + WHY

Code the documented contracture/scar, then the specific burn code with S. Do not code the burn as acute.

I.C.19.b

Coding injuries

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

Code individual documented injuries rather than a nonspecific multiple-injury code when details exist. Do not separately code superficial injuries associated with a more severe injury of the same site unless directed.

FICTIONAL PATIENT EXAMPLE

Avery has documented fractures at two separate sites.



CODING ANSWER / ACTION + WHY

Verify each specific fracture code and sequence by severity/reason for care. Do not replace known sites with unspecified multiple injuries.

I.C.19.c

Traumatic fractures

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

Use site, laterality, displacement, open/closed and encounter/healing details. Defaults for missing displacement or open/closed status follow the guideline.

FICTIONAL PATIENT EXAMPLE

Avery has a documented fracture with no displacement or open/closed description.



CODING ANSWER / ACTION + WHY

Apply the displaced and closed defaults where relevant after checking the specific entry; do not infer an open fracture from treatment alone.

I.C.19.c

Open fractures and healing

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

Fracture seventh characters distinguish treatment phase and, when applicable, Gustilo type and delayed/nonunion/malunion. Use the documented healing state.

FICTIONAL PATIENT EXAMPLE

Avery returns for a fracture diagnosed as nonunion.



CODING ANSWER / ACTION + WHY

Verify the site-specific code and nonunion seventh character; do not use routine healing.

I.C.19.d

Burns and corrosions

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

Distinguish thermal burns from chemical corrosions; code site and depth. When several burns exist, sequence the highest degree first.

FICTIONAL PATIENT EXAMPLE

Avery has second- and third-degree burns at different documented sites.



CODING ANSWER / ACTION + WHY

Verify each site/depth code and list the third-degree burn first under the burn rule.

I.C.19.d

Burn depth at same site

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

At the same local site, code only the highest degree of burn. Add infection and extent detail when required and supported.

FICTIONAL PATIENT EXAMPLE

Avery has second- and third-degree burns of the same local site.



CODING ANSWER / ACTION + WHY

Use the third-degree site code, not both depths for that one site; verify the encounter character.

I.C.19.e.1-4

Drug and chemical table conventions

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

Use the Table to find the drug and event type, then verify the Tabular List. Code separate agents unless a combination exists; do not repeat the same unique code.

FICTIONAL PATIENT EXAMPLE

Avery has adverse reactions to two drugs that map to one identical code.



CODING ANSWER / ACTION + WHY

Report that unique drug code once, with supported manifestations. Do not duplicate the code.

I.C.19.e.5(a)

Adverse effects of correct use

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

For an adverse effect of a correctly prescribed and properly taken drug, code the reaction first and the drug adverse-effect code second.

FICTIONAL PATIENT EXAMPLE

Avery has allergic dermatitis caused by correctly taken amoxicillin.



CODING ANSWER / ACTION + WHY

L27.0 then T36.0X5A during active treatment, after verification. The dose was correct.

I.C.19.e.5(b)

Poisoning

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

Incorrect dose, substance or route is poisoning. Code the drug poisoning first, then manifestations.

FICTIONAL PATIENT EXAMPLE

Avery accidentally takes twice the prescribed diazepam dose and develops nausea with vomiting.



CODING ANSWER / ACTION + WHY

T42.4X1A then R11.2 during active treatment. The incorrect dose makes this poisoning.

I.C.19.e.5(c)

Underdosing

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

Taking less medication than prescribed is underdosing. Code resulting relapse/condition first when appropriate; underdosing does not lead. Add documented reason/nonadherence detail as directed.

FICTIONAL PATIENT EXAMPLE

Avery takes less insulin than prescribed and develops diabetic hyperglycemia.



CODING ANSWER / ACTION + WHY

Verify the diabetes manifestation first, then T38.3X6A and applicable reason detail. Do not classify underdosing as poisoning.

I.C.19.e.5(d)

Toxic effects

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

Toxic effects involve harmful nonmedicinal substances. Identify substance, intent and encounter; add manifestations as directed.

FICTIONAL PATIENT EXAMPLE

Avery has confirmed accidental carbon monoxide poisoning receiving active treatment.



CODING ANSWER / ACTION + WHY

T58.91XA for accidental carbon monoxide toxic effect from an unspecified source, after verification.

I.C.19.f

Adult and child abuse, neglect and maltreatment

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

Distinguish confirmed from suspected abuse. Sequence the applicable abuse code and add injury/perpetrator detail as directed; ruled-out suspected abuse uses a different pathway.



FICTIONAL PATIENT EXAMPLE

The provider documents suspected adult physical abuse, not confirmed.

CODING ANSWER / ACTION + WHY

Verify the appropriate suspected-abuse code, not confirmed abuse; add reportable injuries and follow the instructions.

I.C.19.g

Complications of care

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

A clinically significant provider-documented causal relationship is required unless classification directs otherwise. Not every post-care event is a complication.



FICTIONAL PATIENT EXAMPLE

Avery develops a rash after treatment, but its cause is not documented.

CODING ANSWER / ACTION + WHY

Clarify the relationship before coding a treatment complication; do not infer causality from timing.

I.C.19.g

Transplant complications

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

A transplant complication generally affects graft function and needs documentation. A condition in a transplant recipient is not automatically a complication.



FICTIONAL PATIENT EXAMPLE

Avery has CKD stage 3b and a functioning kidney transplant, without a documented graft complication.

CODING ANSWER / ACTION + WHY

N18.32 and Z94.0 as applicable. Do not infer transplant failure.

I.C.20.a

External cause coding: general rules

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

External cause codes supplement the injury/condition, never lead. National reporting is not universally mandatory; comply with applicable state/payer requirements.



FICTIONAL PATIENT EXAMPLE

Avery is treated for an injury caused by a documented fall.

CODING ANSWER / ACTION + WHY

Injury first; add the verified fall cause as required/appropriate. Match the injury treatment-phase character.

I.C.20.b

Place of occurrence

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

Use a place code when supported, generally with the initial encounter; do not invent a place when none is documented.

FICTIONAL PATIENT EXAMPLE

Avery's injury occurred in a documented home location.



CODING ANSWER / ACTION + WHY

Verify the appropriate Y92.- location after the injury/cause codes. Do not assume a room.

I.C.20.c

Activity

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

Use the documented activity code as appropriate, generally at the initial encounter. Do not assume activity from injury type.

FICTIONAL PATIENT EXAMPLE

Avery is injured while performing a documented recreational activity.



CODING ANSWER / ACTION + WHY

Verify the applicable Y93.- code if reporting it. Do not infer work or sport from the fracture.

I.C.20.d

Place, activity and status with other causes

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

These contextual codes accompany other external cause detail; they do not replace the cause and do not lead.

FICTIONAL PATIENT EXAMPLE

Avery is injured during a documented paid work task at a known site.



CODING ANSWER / ACTION + WHY

Injury and cause first, then applicable place/activity/status codes; verify each detail.

I.C.20.e

Reporting-format limits

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

When external cause fields are limited, prioritize cause/intent most related to the principal injury over place/activity/status detail.

FICTIONAL PATIENT EXAMPLE

Avery's claim allows only one external cause field.



CODING ANSWER / ACTION + WHY

Use the most relevant cause/intent code, not a place code alone.

I.C.20.f

Multiple external causes

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

Report multiple causes when they explain distinct events and no combination fully describes them. Follow priority rules for abuse, terrorism and cataclysm.

FICTIONAL PATIENT EXAMPLE

Avery has injuries from two separate documented events.



CODING ANSWER / ACTION + WHY

Verify needed cause codes and their priority, after the injury codes. Avoid redundant causes already captured in a combination.

I.C.20.g

Abuse external causes

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

Confirmed abuse uses the applicable abuse and perpetrator pathways; do not assign accidental intent to confirmed assault.

FICTIONAL PATIENT EXAMPLE

Avery's injury is documented as caused by confirmed physical abuse.



CODING ANSWER / ACTION + WHY

Follow the confirmed-abuse code sequence and applicable perpetrator details. Do not default to accidental injury.

I.C.20.h

Unknown versus undetermined intent

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

Unknown/unspecified intent generally defaults to accidental; undetermined is used only when the record explicitly says intent cannot be determined.



FICTIONAL PATIENT EXAMPLE

Avery's toxic exposure has no stated intent.

CODING ANSWER / ACTION + WHY

Use accidental intent unless another instruction applies; do not choose undetermined merely because the record is silent.

I.C.20.i

Sequelae of external causes

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

For residual effects, use the appropriate external cause code with S when applicable; do not mix acute-cause coding with a residual-only encounter.



FICTIONAL PATIENT EXAMPLE

Avery receives care only for a residual of an old fall injury.

CODING ANSWER / ACTION + WHY

Residual first, applicable injury-sequela and external-cause-sequela detail afterward, as instructed.

I.C.20.j

Terrorism

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

Use terrorism codes when the event is identified as terrorism by the appropriate federal authority. Do not infer it from violent circumstances.



FICTIONAL PATIENT EXAMPLE

Avery is injured in an officially identified terrorist event.

CODING ANSWER / ACTION + WHY

Verify Y38.- and associated injury codes with the documented event and patient role.

I.C.20.k

External cause status

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

Status codes identify civilian work, military activity or other status when documented; follow timing/one-code restrictions.



FICTIONAL PATIENT EXAMPLE

Avery is injured while doing documented paid civilian work.

CODING ANSWER / ACTION + WHY

Y99.0 as appropriate after the injury/cause codes. Do not presume work status from location alone.

I.C.21.a

Z codes in any setting

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

Z codes may lead or be additional depending on purpose and code restrictions. They are not limited to healthy patients.

FICTIONAL PATIENT EXAMPLE

Avery attends only for vaccination.



CODING ANSWER / ACTION + WHY

Z23. A Z code can be the first-listed reason for care.

I.C.21.b

Reason for encounter or extra information

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

Z codes can identify the encounter purpose or explain context affecting care; a procedure code may also be needed separately for services.

FICTIONAL PATIENT EXAMPLE

Avery's visit is solely for HIV screening, without symptoms or exposure.



CODING ANSWER / ACTION + WHY

Z11.4. It describes the reason, not a confirmed HIV diagnosis.

I.C.21.c.1

Contact/exposure

ALL SETTINGS



GUIDELINE IN PLAIN LANGUAGE

Use exposure coding when actual or suspected contact with an infection is documented and no established current infection replaces the reason.

FICTIONAL PATIENT EXAMPLE

Avery has asymptomatic household exposure to COVID-19 without diagnosed infection.

CODING ANSWER / ACTION + WHY

Z20.822. Do not use routine screening solely because a test is performed.

I.C.21.c.2

Inoculations and vaccinations

ALL SETTINGS



GUIDELINE IN PLAIN LANGUAGE

Use Z23 for a vaccination encounter; use separate procedure reporting for administration when applicable.

FICTIONAL PATIENT EXAMPLE

Avery presents only for an influenza vaccine.

CODING ANSWER / ACTION + WHY

Z23. The diagnosis code identifies the vaccination encounter.

I.C.21.c.3

Status

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

Status describes a current state such as a transplant or device and differs from history or a complication.

FICTIONAL PATIENT EXAMPLE

Avery has a functioning transplanted kidney relevant to care.



CODING ANSWER / ACTION + WHY

Z94.0 when reportable. Do not code a transplant complication without support.

I.C.21.c.4

History

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

Personal history describes a past condition no longer present; report relevant history affecting care. Family history is different.

FICTIONAL PATIENT EXAMPLE

Avery's breast cancer is eradicated with no ongoing treatment or residual malignancy.



CODING ANSWER / ACTION + WHY

Z85.3 when relevant. Do not report active cancer.

I.C.21.c.5

Screening

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

Screening looks for disease in an apparently well person. Testing prompted by symptoms is diagnostic instead.

FICTIONAL PATIENT EXAMPLE

Avery receives an asymptomatic screening mammogram without symptoms.



CODING ANSWER / ACTION + WHY

Z12.31. If a breast symptom prompted testing, code that reason instead.

I.C.21.c.6

Observation

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

Observation Z codes apply to suspected conditions ruled out in a person without signs/symptoms, under the specific code instructions.

FICTIONAL PATIENT EXAMPLE

Avery is observed after an event for a suspected condition that is ruled out, without symptoms.



CODING ANSWER / ACTION + WHY

Verify the appropriate Z03/Z04 code; do not use an observation code to replace a documented symptom.

I.C.21.c.7

Aftercare

ALL SETTINGS



GUIDELINE IN PLAIN LANGUAGE

Aftercare is care during healing after initial treatment. Injury healing usually uses the injury code with the correct subsequent character instead of an aftercare Z code.

FICTIONAL PATIENT EXAMPLE

Avery returns for uncomplicated aftercare following a joint replacement done for arthritis.

CODING ANSWER / ACTION + WHY

Z47.1 plus the appropriate joint-presence code, after verification. Injury-related recovery uses its injury pathway.

I.C.21.c.8

Follow-up

ALL SETTINGS



GUIDELINE IN PLAIN LANGUAGE

Follow-up is surveillance after completed treatment, with no continuing condition. Add relevant history; residuals or active disease follow different pathways.

FICTIONAL PATIENT EXAMPLE

Avery has a normal follow-up after completed breast cancer treatment.

CODING ANSWER / ACTION + WHY

Z08 then Z85.3. This is not active treatment or surgical healing.

I.C.21.c.9

Donors

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

Use donor codes for living people donating tissue or organs. Do not use them for a deceased donor record.

FICTIONAL PATIENT EXAMPLE

Avery is a living kidney donor evaluated in that capacity.



CODING ANSWER / ACTION + WHY

Verify Z52.4 for kidney donor status/encounter as applicable to the documented service.

I.C.21.c.10

Counseling

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

Use an applicable counseling code when counseling is the encounter purpose and a more specific instruction does not supersede it.

FICTIONAL PATIENT EXAMPLE

Avery returns solely for counseling about a negative HIV result.



CODING ANSWER / ACTION + WHY

Z71.7 under HIV testing guidance.

I.C.21.c.11

Encounters for obstetrical and reproductive services

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

Choose supervision, reproductive or pregnancy-testing codes by the documented encounter purpose; complications need obstetric coding.

FICTIONAL PATIENT EXAMPLE

Avery attends only for a pregnancy test, confirmed negative.



CODING ANSWER / ACTION + WHY

Z32.02. A negative test encounter is not supervision of pregnancy.

I.C.21.c.12

Routine and administrative examinations

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

Distinguish general medical examinations from administrative examinations and preprocedural evaluations.

FICTIONAL PATIENT EXAMPLE

Avery has a routine adult health exam with no abnormal findings.



CODING ANSWER / ACTION + WHY

Z00.00. Do not use the administrative-exam pathway for an ordinary preventive examination.

I.C.21.c.13

Miscellaneous Z codes

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

Miscellaneous encounter/status codes have their own first-listed versus additional-only restrictions. Read the Tabular instructions rather than applying one rule to all.

FICTIONAL PATIENT EXAMPLE

Avery has a documented adult BMI of 33 with provider-diagnosed obesity.



CODING ANSWER / ACTION + WHY

Z68.33 is additional to the appropriate obesity code when reportable; it does not lead under BMI guidance.

I.C.21.c.14

Nonspecific Z codes

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

Use nonspecific Z codes only when no more specific encounter or circumstance is documented.

FICTIONAL PATIENT EXAMPLE

Avery's chart identifies a specific screening purpose.



CODING ANSWER / ACTION + WHY

Use the specific screening code rather than a nonspecific encounter code. Verify the actual test purpose.

I.C.21.c.15

Z codes usable only as principal/first-listed

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

Some Z codes are restricted to principal/first-listed use; consult the official list and Tabular notes.

FICTIONAL PATIENT EXAMPLE

Avery's sole visit is administration of antineoplastic chemotherapy.



CODING ANSWER / ACTION + WHY

Z51.11 first, followed by the active cancer. Do not treat the encounter code as optional context only.

I.C.21.c.16

Newborns and infants

NEWBORN/PERINATAL

GUIDELINE IN PLAIN LANGUAGE

Use newborn/infant encounter codes for their intended contexts. Z38 identifies the birth record, not every infant encounter.

FICTIONAL PATIENT EXAMPLE

A healthy single liveborn infant is born in hospital by vaginal delivery.



CODING ANSWER / ACTION + WHY

Z38.00 on the birth record; later routine child checks use their own codes.

I.C.21.c.17

Social determinants of health

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

Code documented social risks affecting health; approved clinician documentation and signed-off patient reports can support SDOH coding. Mere demographic facts are insufficient.

FICTIONAL PATIENT EXAMPLE

Avery expresses concern about food availability; the clinician records food insecurity in the official record.



CODING ANSWER / ACTION + WHY

Z59.41 when reportable. Do not infer food insecurity from income alone.

I.C.22

Codes for Special Purposes

ALL SETTINGS

GUIDELINE IN PLAIN LANGUAGE

The chapter directs users to the specific vaping, COVID-19 and post-COVID guidelines rather than a single universal U-code rule.

FICTIONAL PATIENT EXAMPLE

Avery has a documented residual symptom from resolved COVID-19.



CODING ANSWER / ACTION + WHY

Code the specific residual and U09.9 as directed, rather than using U07.1 for active infection.